NEW PATIENT CASE HISTORY

Please complete this form and bring it with you to your first appointment.

Name _____ Date_____
Address_____ City_____ State_____ Zip_____
Home phone_____ Work phone_____ Cell phone_____
Email _____
Social Security #_____ Driver License # & State_____
Age _____Birthdate_____ Sex_____ Status M□ S□ W□ D□ No. of children_____
Occupation _____Employer _____Years employed_____
Employer's Address _____City_____ State_____ Zip_____
Spouse's name_____ Occupation_____ Employer_____
Person responsible for this account_____
What is your major complaint_____
_____
Other complaints_____
How long have you had this condition? _____ Have you had this or similar condition in the past?_____
What activities aggravate this condition?_____
Is this condition : Getting worse □ Constant □ Comes and Goes □
Is this condition interfering with: Work □ Sleep □ Daily routine □ Other_____
How long has it been since you felt really good?_____
List surgeries and dates_____
_____
Are you taking medications _____ If so, what kind_____
Any non-prescription drugs_____ If so, what kind_____
Other doctors seen for this condition: MD□ DC□ DO□ DDS□
Doctor's Name_____ Diagnosis_____
Did you have: X-Rays □ Urinalysis □ Blood Tests □ Other_____
Treatment: Medication_____ Physical Therapy_____
Results_____ Length of time under care_____
Were you off work? Yes □ No □ If so, how long_____
Have you returned to your job? Yes □ No □ If no, why not_____

Insurance Information

Are you covered by □Medicare □ Other Insurance: Company Name_____
Secondary Insurance Company_____
Is your condition due to: □ Illness □ Accident □ Other_____

Accident Information (IF AUTO ACCIDENT PLEASE COMPLETE PERSONAL INJURY QUESTIONAIRE)

Did your accident occur at work? Yes □ No □ Were you in an auto accident? Yes □ No □
Date of accident_____ Time_____ Work Injury reported to employer? Yes □ No □
Description of accident_____
_____
Were you injured? Yes □ No □ How?_____
Location _____
Were you unconscious? _____ Fractures _____ Cuts _____ Bruises _____
Where did you receive treatment? _____
Were you hospitalized? Yes □ No □ If so, number of days_____ Hospital doctor_____
Have you had any other personal injury or accident? Past year □ Past 5 years □ Over 5 years □ Never □
Is so, describe_____

Do you have an attorney? Yes □ No □ Name and phone number_____

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also affirm that all answers given on this and any other documents are true and correct to the best of my knowledge.

Patient's signature_____ Date:_____

Please check (X) all that apply.

Head:

- ☐ Headache
- ☐ Sinus
- ☐ entire head
- ☐ back of head
- ☐ forehead
- ☐ temples
- ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

Neck:

- ☐ Pain in neck
- ☐ Neck pain with movement
- ☐ Forward
- ☐ Backward
- ☐ Turn to left
- ☐ Turn to right
- ☐ Bend to left
- ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

Shoulders:

- ☐ Pain in shoulder (R - L)
- ☐ Pain across shoulders
- ☐ Bursitis (R - L)
- ☐ Arthritis (R - L)
- ☐ Can't raise arm
- ☐ above shoulder level
- ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve
- ☐ Muscle spasms in shoulder

Arms & Hands

- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Pins & needles-arms

Arms & Hands (continued)

- ☐ Pins & needles -fingers
- ☐ Numbness in arms (R - L)
- ☐ Numbness in fingers (R - L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

Mid-Back:

- ☐ Mid-back pain
- ☐ Location_____
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

Chest:

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Dimpled or orange peel breast
- ☐ Irregular heartbeat

Abdomen:

- ☐ Nervous stomach
- ☐ Foods can't eat_____
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

Low Back:

- ☐ Low back pain
- ☐ Upper lumbar
- ☐ Lower lumbar
- ☐ Sacroiliac

Low back pain is worse when:

- ☐ working
- ☐ lifting
- ☐ stooping
- ☐ standing
- ☐ sitting
- ☐ bending
- ☐ coughing
- ☐ lying down or sleeping
- ☐ walking
- ☐ Pain relieves when_____
- ☐ Slipped disk
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

Hips, Legs & Feet

- ☐ Pain in buttocks (R - L)
- ☐ Pain in hip joints (R - L)
- ☐ Pain down leg (R - L)
- ☐ Pain down both legs
- ☐ Knee pain
  - ☐ Inside_____
  - ☐ Outside____
- ☐ Leg cramps
- ☐ Cramps in feet (R - L)
- ☐ Pins & needles-legs (R - L)
- ☐ Numbness of leg (R - L)
- ☐ Numbness of feet (R - L)
- ☐ Numbness of toes (R - L)
- ☐ Feet feel cold
- ☐ Swollen ankles (R - L)
- ☐ Swollen feet (R - L)

Women Only:

- ☐ Menstrual Pain _____(area)
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle _____days
- ☐ Birth control _____(type)
- ☐ Hysterectomy
- ☐ Cancer_____(type)
- ☐ Discharge
- ☐ Color_____
- ☐ Tumors
- ☐ Abortions
- ☐ Menopause

Men Only:

- ☐ Urinary frequency
- ☐ Difficulty in starting
- ☐ Night urination
- ☐ Prostate pain/swelling

General:

- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep_____(hrs)
- ☐ Loss of sleep_____(hrs)
- ☐ Loss of weight_____(lbs.)
- ☐ Gain weight _____(lbs.)
- ☐ Coffee_____(cups/day)
- ☐ Tea_____(cups/day)
- ☐ Cigarettes_____(packs/day)
- ☐ Other_____
- ☐ Diabetes
- ☐ Hypoglycemia

Remarks:_____

_____

_____

_____

_____

_____

AUTO ACCIDENT PERSONAL INJURY QUESTIONNAIRE

Please complete this form and bring it with you to your first appointment.

Name _____ Date_____

Address_____ City_____ State_____ Zip_____

Home phone_____ Work #_____ Cell #_____

Social Security #_____ Driver License # & State_____

Age _____Birthdate_____ Sex_____ Marital Status ( ) M ( ) S ( ) W ( ) D

Email address_____

Employer _____

Employer's Address _____City_____ State____ Zip_____

Your Ins. Co._____ Policy #_____ Agent_____

Driver/Other Vehicle_____ Ins Co._____ Policy #_____

Have you retained an attorney? ( ) Yes ( ) No If yes, Name_____

Were there any witnesses? ( ) Yes ( ) No If yes, Name_____

Previous Health History

Did you have physical complaints **BEFORE THE ACCIDENT?** ( ) Yes ( ) No

If yes, please describe in detail:_____

_____

_____

How long have you had this condition?_____ Have you had this or similar condition in the past?_____

What activities aggravate this condition?_____

Is this condition : ( ) Getting worse ( ) Constant ( ) Comes and Goes

Is this condition interfering with: ( ) Work ( ) Sleep ( ) Daily routine ( ) Other_____

How long has it been since you felt really good?_____

List surgeries and dates_____

_____

Are you taking medications? ( ) Yes ( ) No If so, what kind_____

Any non-prescription drugs? ( ) Yes ( ) No If so, what kind_____

Other doctors seen for this condition: Doctor's Name_____

Diagnosis_____ Did you have: ( ) X-Rays ( ) Urinalysis ( ) Blood Tests

Treatment: Medication_____ Physical Therapy_____

Results_____ Length of time under care_____

Were you off work? ( ) Yes ( ) No If so, how long_____

Have you returned to your job? ( ) Yes ( ) No If no, why not_____

NATURE OF ACCIDENT

1. Date of Accident_____ Time of Day_____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle?_____ In other vehicle?_____
4. Street or intersection where accident occurred_____
5. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
6. Were you knocked unconscious? ( ) Yes ( ) No
7. Were police notified? ( ) Yes ( ) No

8. Describe accident in your own words:_____

_____

_____

9. Please describe how you felt:

a. DURING the accident_____

b. IMMEDIATELY after the accident_____

c. LATER that day_____

d. The NEXT day_____

10. Describe your PRESENT complaints and symptoms_____

_____

11. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No

If yes please describe:_____

12. Does any previous illness relate to this case? ( ) Yes ( ) No

If yes please describe:_____

13. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe including date(s) and type(s) as well as injuries received:_____

_____

14. Where were you taken after THIS accident? _____

15. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address_____

16. What type of treatment did you receive?_____

_____

17. Since THIS accident occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

18. **CHECK SYMPTOMS YOU HAVE HAD SINCE THIS ACCIDENT:**

☐ Headache	☐ Dizziness	☐ Lights bother eyes	☐ Diarrhea
☐ Neck pain	☐ Head seems heavy	☐ Loss of memory	☐ Feet cold
☐ Neck stiff	☐ Pins & needles - arms	☐ Ringing in ears	☐ Hands cold
☐ Sleeping problems	☐ Pins & needles in legs	☐ Face flushed	☐ Stomach upset
☐ Back Pain	☐ Numbness in fingers	☐ Buzzing in ears	☐ Constipation
☐ Nervousness	☐ Numbness in toes	☐ Loss of balance	☐ Cold sweats
☐ Tension	☐ Shortness of breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of smell	☐ _____
☐ Chest pain	☐ Depression	☐ Loss of taste	

Symptoms other that above_____

19. Have you lost time from work as a result of THIS accident? ( ) Yes ( ) No If yes please complete:

a. Last Day Worked_____ b. Type of Employment_____

20. Do you have any activity restrictions as a result of THIS injury? ( ) Yes ( ) No

If yes please describe in detail:_____

_____

_____

21. Other pertinent information_____

_____

_____ _____

Patient's Signature **Date**